Assembly Bill No. 3251

CHAPTER 1091

An act to add Section 1383.1 to the Health and Safety Code, and to add Sections 10123.67 and 11512.61 to the Insurance Code, relating to health care.

[Approved by Governor September 29, 1996. Filed with Secretary of State September 30, 1996.]

LEGISLATIVE COUNSEL'S DIGEST

AB 3251, Gallegos. Health care service plans: independent medical opinions.

Existing law provides for the licensure and regulation of health care service plans administered by the Commissioner of Corporations. Existing law authorizes an enrollee of a health care service plan to select as a primary care physician any available primary care physician who contracts with the plan in the service plan area where the enrollee lives or works. Under existing law, willful violation of any of these provisions is a misdemeanor. Existing law provides for the regulation of disability insurers and nonprofit hospital service plans by the Department of Insurance.

This bill would require every health care service plan, with specified exceptions, to file with the Department of Corporations a written policy describing the manner in which the plan determines if a second medical opinion is medically necessary and appropriate. The bill would require notice of the policy and related information to be provided to all enrollees. By changing the definition of a crime, the bill would impose a state-mandated local program.

The bill would impose similar requirements on nonprofit hospital service plans and certain disability insurers. It would provide that the written policy would not be subject to approval or disapproval by the Department of Insurance.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

The people of the State of California do enact as follows:

SECTION 1. Section 1383.1 is added to the Health and Safety Code, to read:

1383.1. (a) On or before July 1, 1997, every health care service plan shall file with the department a written policy describing the manner in which the plan determines if a second medical opinion is medically necessary and appropriate. Notice of the policy and information regarding the manner in which an enrollee may receive a second medical opinion shall be provided to all enrollees in the plan's evidence of coverage. The written policy shall describe the manner in which requests for a second medical opinion are reviewed by the plan.

(b) This section shall not apply to any health care service plan contract authorized under Article 5.6 (commencing with Section 1374.60).

(c) Nothing in this section shall require a health care service plan to cover services or provide benefits that are not otherwise covered under the terms and conditions of the plan contract, nor to provide services through providers who are not under contract with the plan.

SEC. 2. Section 10123.67 is added to the Insurance Code, immediately following Section 10123.6, to read:

10123.67. (a) On or before July 1, 1997, every disability insurer that covers hospital, medical, or surgical expenses, as described in subdivision (b), shall file with the department a written policy, which is not subject to approval or disapproval by the department, describing the manner in which the insurer determines if a second medical opinion is medically necessary and appropriate. Notice of the policy and information regarding the manner in which an insured may receive a second medical opinion shall be provided to all insureds in the insurer's evidence of coverage. The written policy shall describe the manner in which requests for a second medical opinion are reviewed by the insurer.

(b) This section shall only apply to disability insurers covering hospital, medical, or surgical expenses that contract with providers for alternative rates pursuant to Section 10133 or 11512 and that limit payments under those policies to services secured by insureds from providers charging alternative rates pursuant to the contracts.

(c) Nothing in this section shall require the disability insurer to cover services or provide benefits that are not otherwise covered under the terms and conditions of the plan contract, nor to provide services through providers who are not under contract with the plan.

SEC. 3. Section 11512.61 is added to the Insurance Code, immediately following 11512.6, to read:

11512.61. On or before July 1, 1997, every nonprofit hospital service plan shall file with the department a written policy, which is not subject to approval or disapproval by the department, describing the manner in which the plan determines if a second medical opinion is medically necessary and appropriate. Notice of the policy and information regarding the manner in which a member may receive a second medical opinion shall be provided to all members. The

written policy shall describe the manner in which requests for a second medical opinion are reviewed by the plan.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

Notwithstanding Section 17580 of the Government Code, unless otherwise specified, the provisions of this act shall become operative on the same date that the act takes effect pursuant to the California Constitution.

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